STATE OF IDAHO
Office of Group Insurance

RETIREE PRESCRIPTION DRUG ASSISTANCE REIMBURSEMENT FORM

- **Reimbursements will be made on the amount paid by the Retiree**
- **Separate forms are required for each retiree**
- **Include receipt for each prescription reflecting out of pocket cost**
- **Must include proof that you have expended $2,000 out-of-pocket in the coverage gap**

★ **Requests that are incomplete will be returned**

RETIREE INFORMATION

Name _____ **DOB**_____ **Phone** _____

Address _____ **City/State/Zip** _____

Part D Plan Carrier _____ **ID#**_____

PRESCRIPTION INFORMATION

1.	_____	_____	_____
	Drug	Date Filled	Amt. Paid
2.	_____	_____	_____
	Drug	Date Filled	Amt. Paid
3.	_____	_____	_____
	Drug	Date Filled	Amt. Paid
4.	_____	_____	_____
	Drug	Date Filled	Amt. Paid
5.	_____	_____	_____
	Drug	Date Filled	Amt. Paid
6.	_____	_____	_____
	Drug	Date Filled	Amt. Paid

* Additional medication expenses can be added on back.

ADDITIONAL PRESCRIPTION INFORMATION

	Drug	Date Filled	Amt. Paid
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____

- Retain copies for your records
- Allow 3-4 weeks for reimbursement

If you need assistance, please contact Office of Group Insurance

1-800-531-0597
(Boise Area: (208) 332-1860)
ogi@adm.idaho.gov

Return Completed Claim Form to:

Office of Group Insurance
P.O. Box 83720
Boise, ID 83720-0035